The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Horne.

DIGEST

Proposed law requires a health insurance issuer to maintain a network that is sufficient in numbers and types of health care providers to ensure that all services to covered persons will be accessible without unreasonable delay. Requires access to emergency services 24 hours per day, 7 days a week.

Proposed law stipulates that where the issuer has an insufficient number or type of providers, the issuer must ensure that the covered person obtains the covered health care service at no greater cost than if the covered health care service is obtained from network providers, or make other arrangements acceptable to the commissioner of insurance.

Proposed law requires that when an out-of-state or out-of-network health care provider agrees to the network contracted reimbursement rate of the covered person's health insurance issuer and a covered person has been diagnosed with or is being treated for a life-threatening, terminal illness, such covered person shall have the right to request covered health care services from that out-of-state or out-of-network provider.

Proposed law necessitates a health insurance issuer to establish and maintain adequate arrangements to ensure a reasonable geographic proximity of participating providers to the business or personal residence of covered persons. Requires the commissioner of insurance to give consideration to the relative availability of health care providers in the service area when determining compliance.

Proposed law requires that when a covered person is referred by a participating provider who finds it medically necessary to refer such covered person to an out-of-network health care provider, the health insurance issuer shall ensure that the covered person incur no greater out of pocket liability than if the covered person received services from a participating provider. Requires a covered person who chooses to access an out-of-network provider to pay for services pursuant to the policy provision of the network.

Proposed law calls for health insurance issuers to make its selection standards for participating providers available for review by the commissioner. Requires issuers' selection standards for participating providers be developed for primary care professionals and each health care professional specialty in accordance with present law.

Proposed law prohibits selection criteria to be established in a manner that would allow a health insurance issuer to avoid high-risk populations or that would exclude providers that treat or specialize in treating populations presenting a risk of higher average claims, losses or health services utilization.

Proposed law does not require a health insurance issuer to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

Proposed law requires a health insurance issuer to monitor the ability, clinical capacity, financial capability and legal authority of its participating providers to furnish all covered health care services to covered persons.

Proposed law prohibits a participating provider from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured an issuer's liability or any amount in excess of the contracted rate for covered services. Restricts a participating provider to collect applicable copayments and deductibles from covered persons pursuant to the evidence of coverage. Requires acquisition of written informed consent detailing the personal financial obligations for non-covered services prior to rendering health care services.

Proposed law provides for the filing of an access plan for each of the health benefit plans that the health insurance issuer offers in the state with the commissioner starting on January 1, 2010. Allows the commissioner to deem sections of the access plan as proprietary or competitive and not to be made public. Requires the issuer to make access plans available on its business premises upon request. Requires changes to an access plan be filed with the commissioner prior to their implementation. Requires filing an updated list of participating providers with the commissioner at least quarterly.

Proposed law requires the access plan to describe or contain at least the issuer's networks, the procedures for making referrals within and outside its network, the process for monitoring and assuring the sufficiency of the network to meet the health care needs of populations that enroll in the health plans, the written policies for adding providers to a closed network as well as the issuer's method of informing covered persons of the health benefit plan's services and features.

Proposed law calls for the access plan to also include the issuer's system for ensuring the coordination of continuity of care for covered persons referred to specialty health care providers, for covered persons using ancillary services, including social services and other community resources and for ensuring appropriate discharge planning. Requires the access plan to detail the issuer's proposed plan for providing continuity of care in the event of contract termination between the issuer and any of its participating providers as required in present law or in the event of the issuer's insolvency or other liability to continue operations. Requires a description of the standards by which the health insurance issuer ensures that the covered health care services to be rendered under the network of providers are reasonably accessible and available.

Proposed law calls for standards to address such issues as the scope of health care services to be provided by the network of providers and the issuer's methods for accessing the health care needs of covered persons and their satisfaction with services as well as the number and type of participating providers necessary to meet the health care needs and service demands of the currently enrolled population and the demands of the population expected to be enrolled over the next twelve months. Requires that these standards address the location of participating providers

within the service area necessary to accommodate the enrolled population, the distance or time that the covered person must travel to access health care services, the addition of participating providers to meet needs based on increases in the number of covered persons, and efforts to address the needs of covered persons with limited English proficiency.

Proposed law requires the issuer to provide sample copies of the participating provider contracts or agreements utilized by the issuer. Allows the filing of one complete sample contract or agreement together with a description of all variable terms and conditions.

Proposed law provides that provider agreements include a provision requiring the provider to comply with applicable administrative policies and procedures of the issuer, a provision requiring the participating provider to cooperate with issuer credentialing and recredentialing processes defined in present law, and a provision requiring the provider to participate and cooperate with the policies and processes involved in utilizations management. Requires provider agreements to also include a provision that the provider maintain and make medical records available to the issuer for the purpose of determining the medical necessity and appropriateness of care and to make such medical records available to appropriate state and federal authorities.

Proposed law requires provider agreements to include a provision mandating that all participating providers to have admitting privileges in at least one hospital with which the issuer has a written provider contract as well as a provision requiring that an issuer provide at least 60 days written notice to each other before terminating the contract without cause. The issuer must make a good faith effort to provide written notice of a termination within 15 days of notice of termination to all covered persons who are patients seen on a regular basis whose contract is terminating. Where a contract termination involves a primary care professional, all covered patients must be notified.

Proposed law requires a provider agreement to include an explanation of the provider's responsibilities for continuation of covered services in the event of contract termination as well as a provision regarding any obligation to provide covered health care services on a 24/7 basis. Requires a provision that an issuer require a participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care and compliance with applicable state and federal laws related to confidentiality of medical or health records. Requires that a provider only be allowed to collect applicable copayments and deductibles from covered persons pursuant to the evidence of coverage and to obtain the covered person's informed written consent detailing their personal financial obligations for non-covered services prior to rendering health care services.

Proposed law requires a provision in a provider agreement that requires a provider to refer all covered services to a provider in the issuer's network when there is a health care provider available in that network. If the provider refers a covered service to an out-of-network provider when a participating provider is available, the referring provider shall be liable for any costs incurred by the covered person that are not reimbursed by the issuer to that out-of- network provider. Also requires a hold harmless provision specifying protection for covered persons in reference to an insolvency.

Proposed law requires that every contract between an issuer and a provider to set forth the established mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible.

Proposed law requires that every contract between an issuer and a provider set forth that in the event of an issuer or intermediary insolvency or their cessation of operations, services to covered persons will continue through the period for which a premium has been paid to the issuer on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever is greater.

Proposed law requires every contract between an issuer and provider to contain a provision that notifies providers of the providers' responsibilities with respect to the issuer's administrative policies and programs including payment terms, utilization review, quality assessment and improvement programs. Requires that every contract also include a provision that does not offer an inducement under the health benefit plan to a participating provider to provide less than medically necessary services.

Proposed law provides that every contract between an issuer and provider contain a provision that does not prohibit a participating provider from discussing treatment options with covered persons regardless of the issuer's position on the treatment options.

Proposed law prohibits the rights and responsibilities under a contract between an issuer and provider from being assigned or delegated by the provider without prior written consent of the issuer. Prohibits an issuer from penalizing a provider who, in good faith, reports to state or federal authorities any act or practice by the issuer that jeopardizes patient health or welfare.

Proposed law requires an issuer to establish a mechanism by which the providers may determine in a timely manner whether or not a person is covered by the issuer. Requires an issuer to establish procedures for resolution of administrative, payment or other disputes between providers and issuers. Restricts a contract between an issuer and provider from containing provisions or definitions that conflict with the managed care plan or proposed law.

Proposed law prohibits an issuer from assigning its statutory responsibility to monitor the offering of covered services to covered persons to an intermediary. Allows an issuer to approve or disapprove participation status of a subcontracted provider in its own or a network of providers in or to deliver covered services to the issuer's covered persons.

Proposed law allows an intermediary to transmit utilization documents and claims paid documentation to the issuer. Requires the issuer to monitor the timeliness and appropriateness of payments made to providers and services received by covered persons. Requires the intermediary to maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for ten years.

Proposed law requires the intermediary to allow the commissioner access to the intermediary's

books, records, financial information and any documentation of services provided in order to determine compliance with proposed law. Authorizes an issuer, in the event of the intermediary's insolvency, to require the assignment to the issuer of the provisions of a provider's contract addressing the provider's obligations to furnish covered services.

Proposed law authorizes the commissioner to institute a corrective action that shall be followed by the health issuer when the commissioner determines that an issuer has not contracted with enough participating providers to ensure accessible health care services in a geographic area. Allows the commissioner to use any of his enforcement powers to obtain compliance with all provisions of proposed law.

Proposed law prohibits the commissioner from acting as arbitrator or mediator regarding a decision not to include a provider in a health benefit plan or in a network of providers, as long as the health issuer has an adequate network. Prohibits the commissioner from settling a dispute regarding any dispute between an issuer, its intermediaries or a network of providers arising by reason of a contract termination.

Proposed law authorizes the commissioner to promulgate reasonable regulations to implement the provisions of proposed law subject to the Louisiana Administrative Procedure Act.

Proposed law authorizes the commissioner to refuse to renew, or may suspend or revoke the certificate of authority of any insurer violating any provisions of proposed law. Authorizes the commissioner to levy a fine not to exceed $100,000 for each violation in lieu of suspension or revocation of a license duly issued.

Effective August 15, 2009.

(Adds R.S. 22:1016-1020)